令和 5 年度労災疾病臨床研究事業費補助金研究　分担研究報告書

健康管理手帳制度による健康診断のネパールでの実施のための研究

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研究要旨

【目的】

移民労働者は送金を通じてネパールの GDP に大きく貢献している。ネパールの人口の多くが海外雇用に従事している。労働力には熟練労働者と非熟練労働者の両方が含まれ、大多数が建設、接客、製造、家事サービス部門で働いている。労働移動プロセスを規制・管理するため、ネパール政府は、ネパール人移民労働者の採用、訓練、福祉を監督する様々な政策や健康診断システムを確立してきた。海外就労中および海外就労からネパールに帰国した後の健康を確保するための支援体制は不十分であった。本研究の目的は、ネパールにおける労働安全衛生（OSH）制度を評価し、海外労働から帰国した移民労働者が健康診断、治療、リハビリテーションを必要とする場合の支援システム開発の可能性を探ることである。

【方法】

ネパールの移民労働者管理、ヘルスケアシステム、OSH サービスの提供システム、及び品質保証システムの現状について文献調査を行った。また、ネパールで働く OSH の専門家に構造化質問票を用いてインタビューを行った。

【結果】

労働・雇用・社会保障省（MoLESS）は、国内の OSH を含む労働移動を規制する最高機関である。OSH は MoLESS にとって優先順位の低い分野に位置付けられており、そのため OSH の管理体制が弱く、人材不足が深刻である。入国前のメディカルチェックを認可された医療機関はあり、本調査を通じて 284 院をリストアップした。しかし、海外就労から帰国した労働者の健康ニーズに対応する機能的なシステムはない。

【考察】

MoLESS と保健・人口省（MOHP）の間には何の連携もない。国内には、定年退職後の労働者、職業性疾患の健康診断、治療、リハビリテーションのための統合システムは規定されていない。

A. 研究目的

ネパールは南アジアの内陸国で、147,516 平方キロメートルの国土を有し、北は中国、南、東、西はインドに隣接している。ネパールの人口は 2021 年に 2,970 万人に達した。2011 年以来、ネパールの人口は約 10%増加している。2022 年の一人当たり GDP は 1083 米ドルである。経済調査 2022/23 によると、ネパールの人口の約 15%が貧困線下にある。ネパールの移民労働者数は人口の 2 割に相当する約 600 万人となっており、そのうち 9 割はマレーシア、カタール、サウジアラビア、UAE に集中している。我が国におけるネパール人労働者については、厚生労働省が発表した 2023 年 10 月末の国籍別・在留資格別外国人労働者数によると、14.6 万人と全体の約 7%を占めている。これは、外国人労働者総数で見ると、ベトナム、中国、フィリピンに次ぐ全体の 4 位に位置している。4 人に 1 人が専門的・技術的分野の在留資格で就労しているものの、全体の約 2/3 が資格外活動で、特に留学が 6 万人となっており、語学学校に通いつつ、アルバイトとして働く移民労働者が多くを占めるものと推察される。2024 年 1 月 1 日に、法務省、外務省、厚生労働省とネパール国労働・雇用・社会保障省との間で、技能実習に関する二国間取決め（協力覚書：MOC）が締結されたことから、今後は技能実習での就労者が増加することが予想される。

このような労働移民の健康は、帰国後の健康を保証するシステムがないため、国にとって課題となっている。ネパールの医療制度は、不十分なインフラ、特に農村部における医療従事者の不足、地理的な問題による医療サービスへのアクセスの悪さ、社会的・経済的障壁、医療保険制度が未成熟であるなどの課題にしばしば直面している。本研究の目的は、ネパールにおける労働安全衛生（OSH）制度を評価し、海外労働から帰国した労働移民が健康診断、治療、リハビリテーションを必要とする場合の支援システム開発の可能性を探ることである。

B. 研究方法

研究目的に基づいて 2 つの研究課題を設定した。

1. ネパールにおける OSH サービスの提供システムとは何か？
2. ネパールにおける OSH サービスの品質保証システムとは何か？

研究課題に基づいて、OSH、職業性疾患、労働法、労働移動などのキーワードを特定した。また、ネパール政府の公式ウェブサイトを通じて、ネパール政府の政策文書や報告書を調査した：

https://moless.gov.np/np

https://www.oshc.gov.np/

https://mohp.gov.np/en/

https://censusnepal.cbs.gov.np/results

さらに、その他の文書、研究論文、出版済みおよび未発表の報告書も使用した。さらに、構造化質問票を用いて労働者 1 名にインタビューを行った。

C. 研究結果

ネパールにおける OSH サービスの提供システム

労働・雇用・社会保障省（MoLESS）は、ネパールの OSH の最高機関であるが、MoLES にとって OSH の優先順位は低い。そのため、OSH を監督・管理するための組織体制は弱く、人材不足も深刻である。保健・人口省（MOHP）と MoLESS の間には機能的なつながりはない。現在の OSH サービスの提供システムは、労働者の健康管理、工場検査、労働検査を規定したネパール労働法によって規定されている。国内の職業性疾患や職業傷害の全体的な発生率／有病率に関する統計は、移民労働者向けのサービスも含め、アクセスしやすい形式では十分にまとめられていない。職業性疾患を専門的に管理する組織が存在しないため、職業性疾患は一般的な保健サービスの枠組みの中で管理されている。

ネパールにおける OSH サービスの品質保証システム

アスベストを含む有害物質にさらされた労働者に対する特別な健康診断制度はない。職業性疾患の調査に使用される X 線写真などの診断ツールに関する基準もない。OSH サービスの品質保証に寄与する規制組織は、作業環境測定と労働者の健康診断関連のものに限られている。

移民労働者の健康診断を実施している医療機関

移民労働者は MOHP が認める政府公認の医療センターで事前健診を受けなければならない。本調査を通じて、この事前健診を行っている医療センターとして、284 院をリストアップした。医療センターの大部分は、ネパールの首都カトマンズを含むバグマティ県に位置する（表 1）。コシ県には約 10%の医療センターがある一方で、カルナリ県には医療センターがない。医療センターの大部分は独立した研究所で、外来患者サービスのみを提供し、入院患者サービスはない。

表 1 移民労働者の事前健診を行っている医療センターの分布

	N = 284
州	
コシ州	28 (10%)
マデシ州	3 (1%)
バグマティ州	241 (85%)
ガンダキ州	3 (1%)
ルンビニ州	8 (3%)
カルナリ州	0 (0%)
スドゥパシュチム州	1 (1%)

表 2 移民労働者の診察を行っている医療機関の分布

番号	医療機関名	州	ベッド数
1	Norvic International Hospital	バグマティ州	200
2	Grande International Hospital	バグマティ州	200
3	Ciwec Hospital Pokhara	ガンダキ州	25
4	Mediciti Hospital	バグマティ州	700
5	Neuro Hospital (National Institute of Neurology)	バグマティ州	100
6	Manipal College of Medical Science	バグマティ州	700
7	CIWEC Clinic	バグマティ州	25
8	IOM Nepal Migration Health Assessment Center	バグマティ州	0

上記の病院は、ネパールへの外国人移住者や旅行者の健康診断で最もよく知られている三次病院で、いずれも複数の専門科を有している。

D. 考察

調査結果に基づき、取り組むべき課題として以下の点が浮かび上がった。

- ネパールにおける OSH サービスの提供システムは、労働者の作業環境測定・健康診断に限られている。
- ネパールにおける OSH サービスには、機能的な品質保証システムが欠如している。

E. 結論

ネパールでは、若者の多くが海外に出稼ぎに行き、日常生活を送っている。しかし、国内の労働力に対するサービスは不十分で、移民労働者に対するサービスは出国前の事前健診に限られている。本調査を通じて、ネパールでの調査を進める上で必要となる連絡担当者を立てることができた。また、ネパールにおける OSH サービスの提供システム及び品質保証システムについての文献調査を終えることができた。一方で、ネパールの病院調査の実施は次年度以降の課題となった。

F. 健康危険情報

該当なし

G. 研究発表

該当なし

H. 知的財産権の出願・登録状況(予定を含む)

1. 特許取得

該当なし

2. 実用新案登録

該当なし

Status of Occupational Safety and health and Quality Assurances of Related Services in Nepal

Overseas Health Checkup Initiative

MAY 14, 2024

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Contents

Abbreviations

AHMIS	-Ayurveda Health Management Information System
CDO	- Chief District Officer
COVID-19	- Corona virus
CSO	- Civil Society Organizations
DDA	- Department of Drug Administration
DIN	-Drug Information Network
DoAA	- Department of Ayurveda and Alternative Medicine
DoEF	- Department of Foreign Employment
DoHS	- Department of Health Services
EHRs	- Electronic health records
EPF	- Employees Provident Fund
EWARS	-Early warning and Reporting System,
FCHV	- Female Community Health Volunteers
FMIS	-Financial Management Information System
GCC	-Golf Cooperation Council
GEFONT	-General Federation of Nepalese Trade Unions
HIIS	-Health Infrastructure Information System
HMIS	- Health Management Information System
HuRIS	-Human Resource Information System,
ILO	-International Labour Organization
LEO	- Labour Employment office
LLGs	- Local Level Government
LMIS	- Logistics Management Information System
MDIS	-Malaria Disease Information System
MIS	- Management Information Systems
MoHP	- Ministry of Health and Population
MoLESS	- Ministry of Labour, Employment, and Social Security
MoSD	- Ministry of Social Development
MPH	- Masters in Public Health
MSS	-Minimum Service Standards

NHPC	- Nepal Health Professional Council
NMC	-Nepal Medical Council (NMC)
OOP	- Out-of-Pocket
OSH	-Occupational Safety and Health
OSHP	-Occupational Safety and Health Project
PHC	-Primary Health Care Centres
PLAMAHS	- Planning and Management of Assets in Health Care System
QAAS	-Quality Assurance and Accreditation Section
SSF	- Social Security Fund (SSF)
TIMS	-Training Information Management System,
UK	- United Kingdom
UN	-United Nations
WHO	- World Health Organizations

1. General Information of Nepal

1.1 Nepal Geographic

The Federal Democratic Republic of Nepal is a landlocked country located in South Asia with China in the north and India in the south, east and west. The country occupies 147,516 sq. km of land and lies between coordinates approximately 28°N and 84°E. Within a short distance, Nepal's topography changes from the alluvial Gangetic plains suitable for agriculture to the frozen lands of the Himalayan mountains. Between the two extremes lie the middle hills. There are several inner Himalayan valleys with desert conditions located at altitudes above 3,600m.

Figure: 1 Map of Nepal

The country is divided into three geographical zones, i.e. Terai (plain), hills and mountains. Nepal is divided into 7 provinces 77 districts and 753 local units including 6 metropolises, 11 sub-metropolises, 246 municipal councils and 481 villages. Kathmandu is the nation's capital and largest city. (1)

1.2 Nepal Population

Nepal is a low-income country situated between China and India. The population of Nepal reached 29.7 million in 2021. Since 2011, Nepal's population has grown by 10.18%. However, the average annual growth rate is 0.93%, a decrease from the data reported in the census report of 2001-2011, which presented a growth rate of 1.35%. The annual population growth is 1.35%. The Gross Domestic Product per capita is US$1083 in 2022. According to the Economic Survey 2022/23, 15.1% of Nepal's population is under the poverty line and the Gini coefficient is about 58.5. The Human Development Index value is 0.602 in 2022. The crude birth rate is 20.0 per 1000 population. The crude death rate is 7.3. The total fertility rate is 2.1. The infant mortality rate is 28 per 1000 live births and the mortality rate under 5 years of age is 33 per 1000 live births. Life expectancy at birth years has improved from 65.3 years in 2000 to 70.9 years in 2019. The fertility rate in Nepal has declined over the years, from 2.516 in 2011 to 1.853 in 2021. (1)

Nepal had the largest population group with 66.8% of the population falling into the working-age group of 15-64 years. Below 15 years, was the second with 27.4% and 65 years and above was the third with 5.8% of the total population in 2021. There is a population of 23958868 aged 10 years and above in the country of which, 65.5% are economically active while 34.5 are economically inactive. The main sector of the work is agriculture (57.3%), followed by wholesale and retail trade (12.5%), construction (8.1%), manufacturing (3.8%), transportation and storage (2.2%), accommodation and food service (1.7%). About 0.2% are only engaged in the mining and quarrying sector. (2)

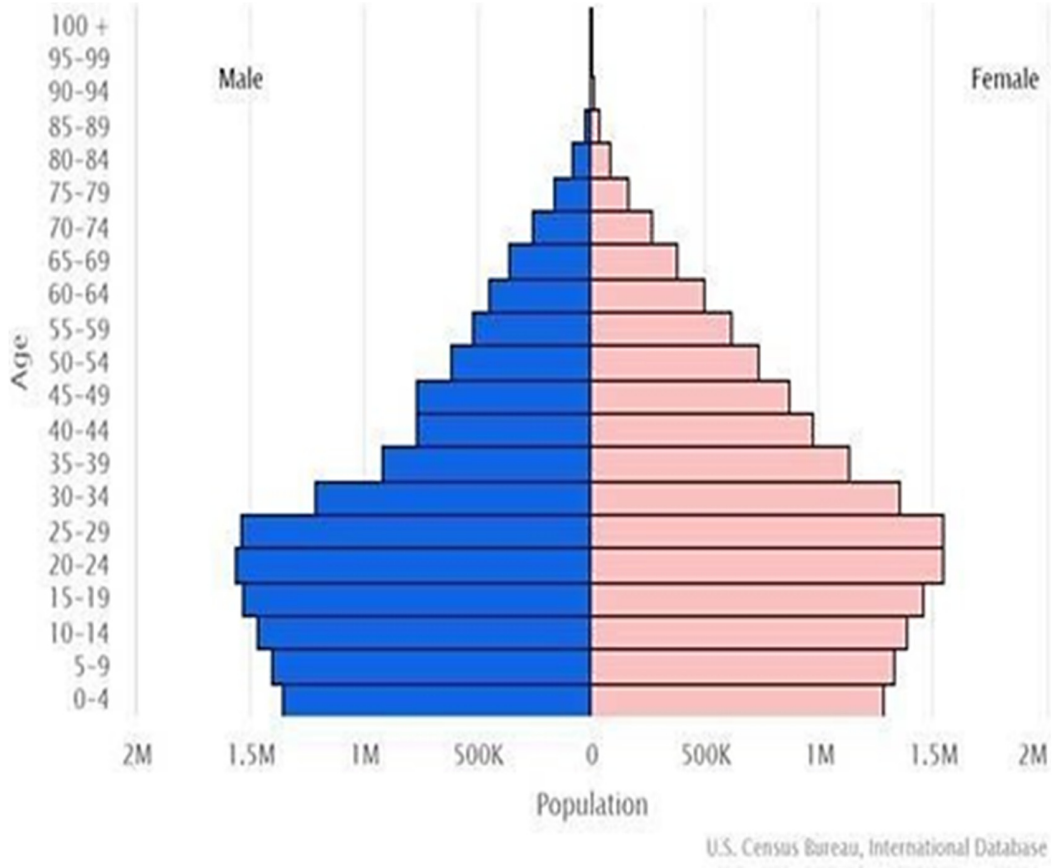

Figure: 2 Population Pyramid of Nepal

Export of workers has driven Nepal's notable pro-poor economic growth: personal remittances reached 25% of GDP in 2020, contrasted with meagre foreign direct investments at 0.4% of GDP. The labour income share fell, and labour productivity with weak progress during the 2010s. There are slight shifts in the structural employment status backed by a tailwind from the service sector. The urbanisation rate stands far below the neighbouring countries. The relatively low unemployment rate at around 5.1% in 2021 is shadowed by a broader underutilization rate of 39%.(3)

Table 1: Socio-demographic indicators of Nepal

Indicators	Value	Year
1.1.1: Working poverty rate (%age ofemployed living below US$1.9 PPP).	3.4%	2021
1.3.1: The population is effectively covered by a social protection system, including socialprotection floors.	17% *	2020

5.5.2: Proportion of Women in senior andmiddle management positions	14%	2017
5.5.2: Proportion of women in managerial positions	13%	2017
8.2.1: Annual growth rate of output per worker (GDP constant 2011 international $ inPPP).	-3.6%	2021
8.3.1: Proportion of informal employment innon-agriculture employment.	78%	2017
8.3.1: Women	82%	2017
8.3.1: Men	75%	2017
8.5.1: Average hourly earnings of women and men employees.	US$1.1	2017
8.5.2: Unemployment rate (Total, 15+)	11%	2017
8.5.2: Women, 15+	13%	2017
8.5.2: Women, 15-24 years	24%	2017
8.5.2: Men, 15+	10%	2017
8.5.2: Men, 15-24 years	20%	2017
8.6.1: Proportion of youth (15-24 years) not in education, employment, or training).	35%	2017
8.7.1: Proportion and number of children aged 5-17 years engaged in economic activity (Total).	19%	2014
8.7.1: Girls	19%	2014
8.7.1: Boys	19%	2014
8.1.1: Non-fatal occupational injuries per100,000 workers	-	-
8.8.1: Fatal occupational injuries per 100,000workers.	-	-
8.8.2: Level of national compliance with labour rights (freedom of association andcollective bargaining)	-	-
9.2.2: Manufacturing employment as a proportion of total employment.	15%	2017
10.4.1: Labour income share as a % of GDP.	37%	2017

1.3 Nepal Labour

1.3.1 General

Nepal has the largest population group with 66.8% of the population falling into the working-age group of 15-64 years. Below 15 years, is the second largest group with 27.4% and 65 years and above was the third largest group with 5.8% of the total population in 2021. There is a population of 23958868 aged 10 years and above in the country of which, 65.5% are economically active while 34.5% are economically inactive. The main sector of work is agriculture (57.3%), followed by wholesale and retail trade (12.5%), construction (8.1%), manufacturing (3.8%), transportation and storage (2.2%), accommodation and food service (1.7%). About 0.2% are only engaged in the mining and quarrying sector.

1.3.2 Social Insurance

Nepal has a long and successful history of provident funds that dates back to 1934 and programs such as the Employees Provident Fund (EPF) have been in the collective memory of the citizens for a few decades. The introduction of mandatory social insurance through the Contribution-based Social Security Act (2017) implemented by the Social Security Fund (SSF), is more recent. The coverage of the existing contribution-based social security programme is less than 15 % of all workers, and the covered are mainly civil servants. (4)

1.3.3 Unemployment Insurance

The unemployment rate for youth aged 15-29 is 19.2% compared to 2.7 per cent for the whole population. Over 400,000 young people are estimated to enter the Labour force every year. These figures indicate the quantitative dimension of the employment challenge in Nepal. However, the unemployment insurance has not been initiated so far. (5)

1.3.4 Organization

Established in 1989, the General Federation of Nepalese Trade Unions (GEFONT), with 27 affiliated union members nationwide, works as an umbrella organization for various trade unions in the fields of agriculture, industry and service sectors. In 2007, with an effort to examine the issues of occupational safety and health through social dialogues with industrial stakeholders in the country.

1.3.5 Labour Migration of Nepal

Nepal has continued to prioritise entering into and renewing bilateral labour migration agreements (BLMAs) with various labour destinations to ensure the safe, orderly and dignified migration of Nepali migrant workers. Between 2019/20 and 2021/22, more than 1.1 million Labour approvals were issued. While the number of Labour approvals issued saw a significant decline in the COVID-19 years of 2019/20 and 2020/21, there was a revival in 2021/22 when the impacts of the pandemic gradually subsided. Nepal welcomed back 203,934 returnees in 2020/21 and 470,978 in 2021/22. Labour migration from Nepal is still a phenomenon dominated by men with women migrant workers accounting for less than 10 per cent of the total labour approvals issued in 2021/22. Madhesh and Province 1 account for the largest share of migrant workers, with each being home to more than a fifth of the total Labour approvals issued in 2021/22. In contrast, Bagmati accounts for the largest share of women migrant workers in foreign employment. (6)

Informality affects countries in this region at varying degrees of economic development, and new forms of work continue to bring challenges on this front even in countries that have made substantial progress. Low- and middle-income countries continue to have elevated levels of informal employment. For instance, Nepal's informal employment rate was around 82% in 2017 and Pakistan's around 84% in 2021 (ILO 2023). The incorporation of effective occupational safety and health (OSH) measures in the informal economy units needs to be considered as an immediate action to protect workers' health and improve their standards of living. It also has to be considered part of a transitional strategy aimed at contributing to poverty alleviation and formalization by combining measures for strengthening the conditions and principles which regulate labour relations, working conditions, OSH and employment opportunities, to allow for economic integration, social cohesion and decent work for all. Identifying the nature, diversity and extent of the informal economy in each country is a complex task. As the informal economy is not covered by national recording, notification and compensation systems, there is scarce information on occupational accidents and diseases arising from hazardous working conditions which could be used for the identification of priority areas for prevention. The magnitude and rate of growth of the informal economy are difficult to establish.

While Nepali citizens migrated to 150 countries between 2019/20 and 2021/22 for employment, the six GCC countries and Malaysia remain the preferred destinations for the overwhelming majority of Nepali migrant workers in the reference period. Countries like Croatia, Cyprus, the Maldives, Malta, Poland, Romania, Turkey, and the UK have also emerged as important employment destinations in the last few

years. Between 2019/20 and 2021/22, although most of the women Nepali migrant workers went to the GCC countries, countries like Croatia, Cyprus, Jordan, Malta, Romania and Turkey were the more prominent, and emerging destinations for women compared to men. (6)

Table 1: List of countries approved for Foreign Labour Migration

S.No.	Country	S.No.	Country	S.No.	Country
1	Afghanistan*	38	Guana	75	Nigeria
2	Albenia	39	Holysee	76	Norway
3	Algeria	40	Hongkong	77	Oman
4	Argentina	41	Hungary	78	Pakistan
5	Armenia	42	Iceland	79	Panama
6	Australia	43	Indonesia	80	Peru
7	Austria	44	Iran	81	Poland
8	Azerbaijan	45	Iraq*	82	Portugal
9	Bahrain	46	Ireland	83	Qatar
10	Bangladesh	47	Israel	84	Republic of Korea
11	Belarus	48	Italy	85	Republic of Slovak
12	Belgiam	49	Japan	86	Rumenia
13	Bolevia	50	Jordan	87	Russia
14	Bosnia Herz	51	Kazakhastan	88	Saipan
15	Brazil	52	Kenya	89	Saudi Arabia
16	Brunei	53	Kosovo	90	Singapore
17	Bulgaria	54	Kuwait	91	Slovenia
18	Canada	55	Laos PDR	92	South Africa
19	Chile	56	Latvia	93	Spain
20	China	57	Lebanon	94	Sri Lanka
21	Columbia	58	Libya*	95	Sweden
22	Combodia	59	Luxzemburg	96	Switzerland
23	Congo	60	Macau	97	Sychelese
24	Costarica	61	Malaysia	98	Tanzania
25	Crotia	62	Maldives	99	Thailand
26	Cuba	63	Malta	100	The Philippines
27	Cyprus	64	Mecedonia	101	Tunetia
28	Czech Republic	65	Mexico	102	Turkey
29	Denmark	66	Moldova	103	Uganda
30	Egypt	67	Mongolia	104	Ukrain
31	Estonia	68	Moritius	105	United Arab Emirates
32	Fiji	69	Morocco	106	United States of America
33	Finland	70	Mozambique	107	Uzbekistan
34	France	71	Myanmar	108	Venezuala
35	Germany	72	Netherland	109	Vietnam
36	Great Britain	73	New Zealand	110	Zambia
37	Greece	74	Nicaragua		

*Currently restricted country

1.3.6 History of Emigration in Nepal

Nepal has a long history (more than 200 years) of emigration and it is an increasing trend. The history of formal Labour migration begins in 1814-1816, after the Nepal-British India war. A total of 4,650 Nepalese youngsters were recruited to the British armed forces as a British Gurkha regiment after the conclusion of the war and the signing of the Treaty of Sugauli in 1816. (7)

Similarly, the migration of Nepalese people for other employment purposes, such as working in the tea estates of Darjeeling and the forest of Assam, India, began in the second half of the 19th century. Economic

migration to the Middle East from South Asia and other parts of the world was spurred on by the oil boom in the early 1970s. International labour migration, mostly to the Gulf States, Malaysia and other South East Asian countries is a new phenomenon of migration in the Nepali context with about 30 years of history. Unexpectedly, foreign labour migration has developed in such a way that it has shifted the agricultural-based Nepali economy towards a remittance-based economy. (7)

1.3.7 Labour export policy and legislation

Nepal has a significant history of labour migration, primarily to countries in the Middle East, Southeast Asia, and parts of Europe. The government of Nepal has established policies and legislation to regulate this migration and protect the rights of Nepali workers abroad. Here are some key points regarding labour export policy and legislation in Nepal: The country has a Labour Migration Act that governs the process of Labour migration from Nepal to foreign countries. This act outlines the procedures, requirements, and regulations that both the recruiting agencies and the workers need to follow. At present, the country's Labour Act 1992 and Labour Rules 1993 neither adequately address current OHS problems faced by industrial workers nor sufficiently provide any standard procedure or system to ensure their good health and safety at workplaces. (8)

Table 2: Policies and regulations

Policies and regulations	Findings
Constitution of Nepal	The constitution of Nepal was promulgated in 2015. Although the constitution does not speak outrightly on directives related to Occupational Health and Safety, nevertheless, it provides fundamental premises for attaining, ensuring, and establishing the highest level of health and safety practices.
Labour Act 2017	The current Labour Act has a mandatory provision of coverage of at least NPR one hundred thousand per year for every worker as part of the medical treatment cost. Similarly, the Act demands coverage of at least NPR seven hundred thousand for every worker as workplace injuries-related treatment cost. The Act specifies that the premium for medical insurance will be paid half by the employer and half by the employee, however, the Act requires the premium for accident insurance to be fully borne by the employer
Public Health Service Act 2018	Clause 44 of this Act speaks on the safety of the health workers in risky zones and encourages them to adopt safety measures. the provision of risk allowance to the workers and in case of serious infection, injury or death, necessary compensation has also been recommended.
15th Strategic Development Plan (2019/2020- 2023/2024)	setting up and implementation of occupational safety and health standards in enterprises to provide dignified employment opportunities to the workers in the country
Labour Rule, 2018	The rule encourages for development of an Occupational Safety and Health Policy for each workplace with the inclusion of a safety preparedness plan, worker's health, machine operation, use of hazardous substances, etc.
National Health Policy Nepal, 2019	To ensure the constitutional rights of citizens to health services through a federal health system and ensure universal access to the health policy. However, does not mention occupational safety and health.

There are no province-level Regulations related to occupational safety and health to date in Nepal. The Labour Act, 2017 and Labour Rules, 2018 which include provisions for occupational safety and health are federal government legislation. Provisions of occupational safety and health directed in the Labour Act, 2017 and its Rules, 2018 apply to all workplaces of seven provinces of Nepal but the provision of safety and health committee mentioned in section 74 of the Act and rule 37 of the Regulation is only applicable in the enterprises employing 20 or more employees.

Findings:

- The laws and regulations do not specify
- Pre-entry screening and post-entry screening for health. However, mentions the establishment of a primary health clinic for first aid management.
- It mentions the rights and duties of the labour migrants and returnees and their health.

1.3.8 Key stakeholders in Labour migration

In the context of labour migration in Nepal, several key stakeholders play significant roles in various aspects of the migration process. These stakeholders include:

Government of Nepal: The government plays a central role in formulating policies, regulations, and laws related to labour migration. It oversees the licensing and regulation of recruitment agencies, provides pre-departure orientation for migrant workers, negotiates bilateral agreements with destination countries, and establishes mechanisms for the protection of migrant workers' rights.

Department of Foreign Employment (DoFE): The DoFE is the government body responsible for regulating and overseeing foreign employment in Nepal. It issues licenses to recruitment agencies, monitors their activities to ensure compliance with the law, provides support services to migrant workers, and facilitates their safe migration.

Ministry of Labour, Employment, and Social Security: This ministry is responsible for formulating labour policies, promoting decent work opportunities, and ensuring the protection of workers' rights, including those of migrant workers. It works closely with other government agencies and international organizations to address issues related to labour migration.

Recruitment Agencies: Recruitment agencies play a crucial role in facilitating labour migration by connecting Nepali workers with employment opportunities abroad. They assist workers in obtaining necessary documentation, provide pre-departure orientation and training, and coordinate with employers and authorities in destination countries.

Migrant Workers: Migrant workers themselves are key stakeholders in labour migration. They seek employment opportunities abroad to improve their economic prospects and support their families back home. Migrant workers rely on recruitment agencies, government services, and support networks to navigate the migration process safely and successfully.

Employers in Destination Countries: Employers in destination countries hire Nepali migrant workers to meet their labour needs in various sectors such as construction, manufacturing, hospitality, and domestic work. They are responsible for providing safe working conditions, fair wages, and other benefits to migrant workers following local laws and regulations.

Civil Society Organizations (CSOs): CSOs play an important role in advocating for the rights of migrant workers, raising awareness about migration-related issues, providing support services to migrant workers and their families, and holding governments and other stakeholders accountable for their actions or lack thereof in protecting migrant workers' rights.

International Organizations and Donor Agencies: International organizations such as the International Labour Organization (ILO), United Nations agencies, and donor agencies provide technical assistance, capacity building, and funding support to Nepal in areas related to labour migration, including policy development, data collection, research, and implementation of programs to promote safe and orderly migration and protect migrant workers' rights.

2. Healthcare System of Nepal

Nepal's health system is distinguished by a comprehensive and inclusive approach that incorporates accessibility, quality assurance, and responsiveness to emerging health challenges. The ongoing commitment to UHC and alignment with global development goals positions Nepal's healthcare system on a trajectory of continuous improvement and resilience. Health service delivery systems in Nepal encompass Allopathic, Ayurvedic, Homeopathic, Unani, Naturopathy, Amchi, Acupuncture/Acupressure, Yoga and other indigenous practices, with a mix of both public and private sectors. The health system underwent and is in continuous restructuring at the federal, provincial, and LLGs, levels adapting to exercise authority and fulfil constitutional mandates at each level of government. At the federal level, five divisions (Policy, Planning and Monitoring Division, Health Coordination Division, Quality Standards and Regulation Division, Population Management Division) and HEOC unit operating under the MoHP, are responsible for managing the policy framework, planning, setting standards, coordination, monitoring, and supervision. Immediate implementation and further planning are conducted through departments- DoHS, the Department of Ayurveda and Alternative Medicine (DoAA), and the Department of Drug Administration (DDA). These departments, through their respective deconcentrated entities viz divisions, centres, and Laboratories, guide their provincial counterparts under the provincial ministries, which in turn support health offices at the district and health coordination units at the Local level of government (LLGs). Public institutions, including Basic health service units/centres and hospitals at the LLGs, primary and secondary hospitals at the provincial level, and tertiary, super-specialized, and academia/teaching hospitals at the federal level, are mandated to deliver health services. The structure encompasses both allopathic, Ayurvedic and alternative medicine health service provisions, extending beyond curative aspects to include promotive, preventive, rehabilitative and palliative dimensions. Furthermore, private health facilities operate at all levels, complementing public institutions. Each institution is mandated to allocate 10% of free beds for impoverished citizens to access health facilities as needed. Moreover, there is an expansion of the health insurance program to cover services beyond basic health services, aiming to reduce out-of-pocket (OOP) expenses and protect against catastrophic health expenditures. This comprehensive network, inclusive of academia/teaching hospitals and super-specialized hospitals at the federal level, contributes to the holistic and community-centric nature of Nepal's health service delivery. (9)

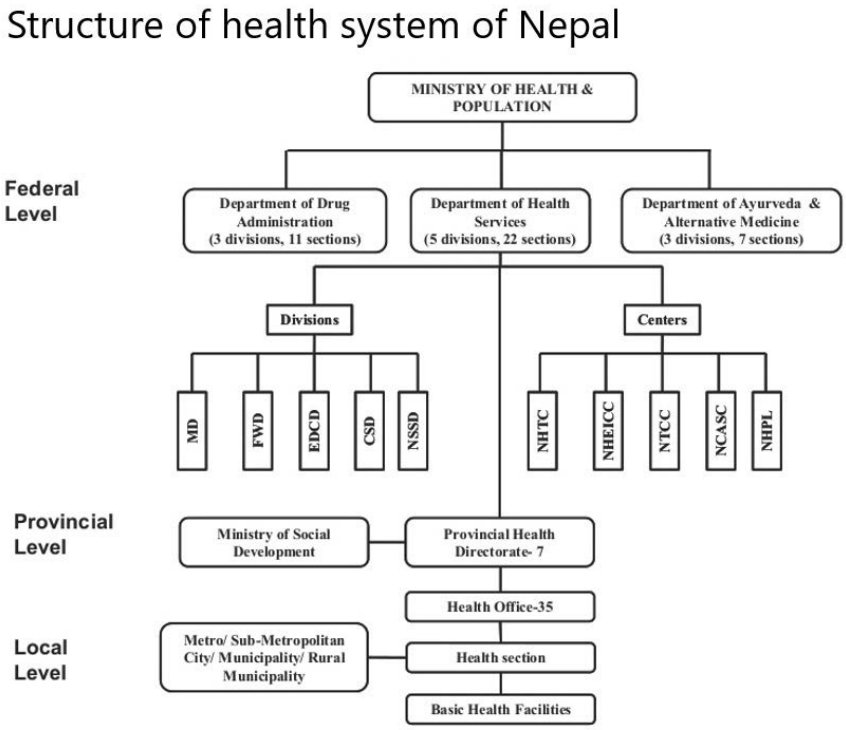

Figure: 3 Structure Health care system of Nepal

2.1 Healthcare Setting

2.1.1 Public Sector

Nepal's pluralistic health system comprises public services and the private sector (including profit and non-profit organizations). The national health system is of three-tier systems i.e. federal, provincial and local levels. At the federal level, under the Ministry of Health and Population, there is a Department of Health Services. Under the Department of Health Services, there are 5 divisions and 22 sections. Its major role is in policy formation, technical backstopping and resource allocation.

The Provincial Health Directorates provide technical backstopping and programme monitoring to district health systems and come directly under the Ministry of Social Development of the Province. The regional, sub-regional, and district hospitals are categorized into three levels of hospitals; Primary, Secondary and Tertiary. There are also training centres, Laboratories, TB centres and medical stores at the provincial level.

The public healthcare system was restructured into local, provincial and state-run facilities in 2015 with Primary Health Care Centres (PHC), Basic Health Centers and Health Posts as basic units for health service delivery. The health post (from an institutional perspective) is the first contact point for basic health services. Besides, the health post is the referral centre of the volunteer cadres of FCHVs as well as a venue for community-based activities such as PHC outreach clinics and EPI clinics. Each level above the HP is a referral point in a network from HP to PHCC, on to district zonal and regional hospitals, and finally to speciality tertiary care centres in Kathmandu. This referral hierarchy has been designed to ensure that the majority of the population receives public health and minor treatment in places accessible to them and at a

price they can afford. Inversely, the system works as a supporting mechanism for lower levels by providing logistical, financial, supervisory, and technical support from the centre to the periphery

2.1.2 Private Sector

Private health service providers are mostly located in urban areas and are used predominantly by wealthier Nepalese patients. In rural areas—where public facilities are accessed more than in urban areas (with a utilisation rate of 39.1% and 26.8%, respectively) but are still not the predominant provider—pharmacies are the chief private providers, mostly used by poor patients. People use private facilities more frequently than public ones—one study found that about 63% of people with an acute illness used the private sector regardless of their economic status. As a result, out-of-pocket spending is high (out-of-pocket payments account for 55% of total health expenditure) and financial protection for patients is poor. Consequently, poor patients utilise health services less than wealthier patient groups, despite having a higher incidence of reported illness. (10)

2.2 Health Facilities

The Ministry of Health is in charge of provincial, district, and commune health facilities and is in charge of developing and implementing health care services at the appropriate level. Numerous health facilities are under the management of the Ministry of Health, including research and Pasteur institutes, universities, colleges, and national hospitals. Every province has a minimum of one provincial hospital, which serves as a support system for national hospitals throughout all stages of care. Basic care, emergency services, and common disease treatment are provided at the district level. Lastly, basic care, health education, and awareness programs are provided at the community level.

Table 1: Number of health facilities

Facility	**Number**
Public hospitals	215
Primary Health Centres	187
Health Posts	3778
Non-public facilities	2551
Basic Health Services Centre	7582
Basic Hospital (5-15 beds)	246
General Hospitals (25-50 beds)	333
General Hospitals (100-300 beds)	79
Specialized hospitals (100 beds and above)	28
Super Specialty Hospitals (50+ Beds)	22
Academic and teaching hospitals (300+beds)	29
Other Types of Health Facilities	2164

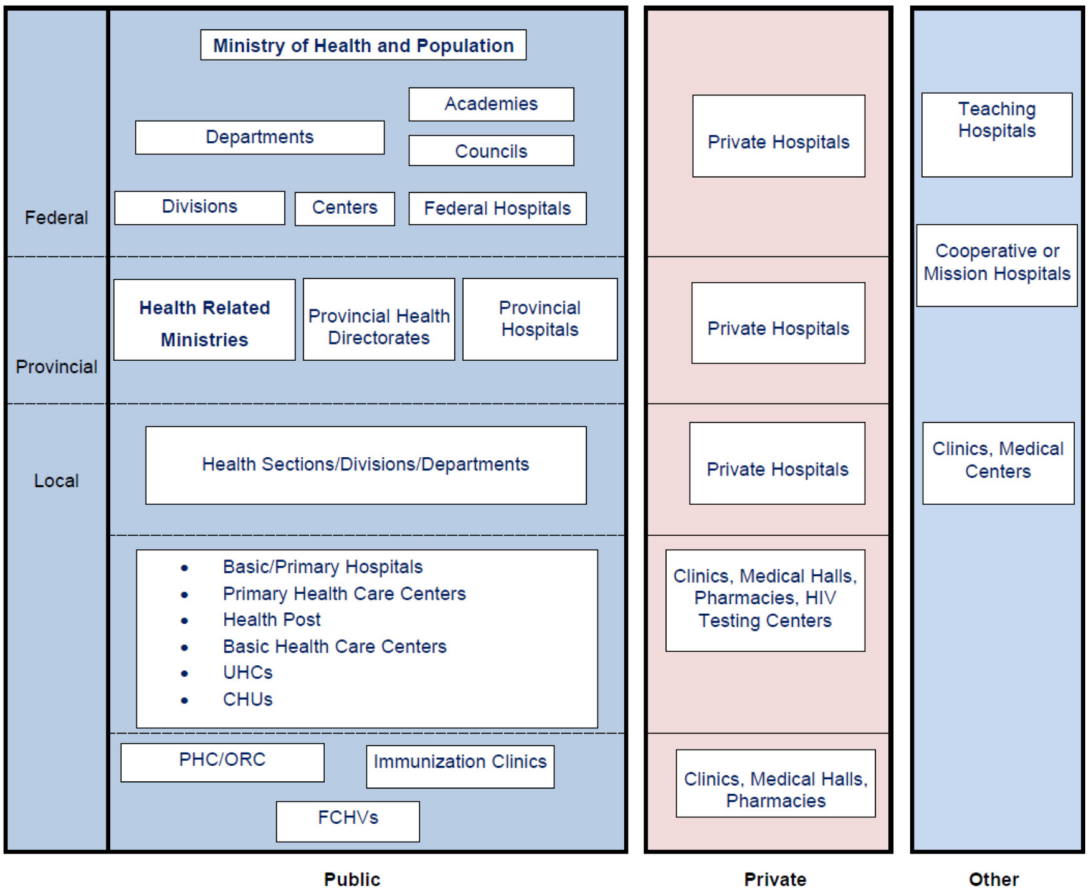

Figure: 4 Organisational chart of Nepal healthcare system, illustrating roles and responsibilities of each component

2.3. Health Finance

The Nepal Constitution included provisions for four types of grants: equalization grants, conditional grants, matching grants, and special grants. The variables used for fiscal equalization grants are population, level of development, and cost-adjusted local government area. Based on the constitutional provisions, the government promulgated two acts related to intergovernmental fiscal transfers (IGFTs) in 2017: the Intergovernmental Fiscal Management Act (IGFMA) and the National Natural Resource and Fiscal Commission Act. Article 6.1 of IGFMA Schedule 3 established the federal divisible fund (FDF) to divide the value-added tax and excise duty on domestic production among the federal, provincial, and local governments. Furthermore, as one of its provisions, Subarticle 2 divided the total amount of the FDF, allocating 70% to the federal government, 15% to provincial governments, and another 15% to local governments. The IGFMA also provides guidelines regarding different types of grants. The most crucial part of an IGFT is the impact on governmental policy objectives, which depends on the formulation of the transfer system and the operational portion of the transfer fund. IGFTs are contingent on the transfer mechanism and the effects of fiscal transfers on basic outcomes such as allocative efficiency, equitable distribution, and macroeconomic stabilization.

The first federal budget was allocated in fiscal year 2017–2018, with fiscal equalization grants and special grants delivered to the local level. Similarly, the IGFMA provided for general revenue sharing and natural resource revenue sharing modalities among the different tiers of government. In 2019, the total health

expenditure per capita in Nepal was US$53.3 Overall, health expenditures represented 4% of the country's gross domestic product (GDP), well below the global average of 10%. Healthcare financing in Nepal involves three principal sources: governmental funding, external contributions, and private expenditures. Government spending accounted for 25% and external contributions represented 16% of Nepal's total health expenditures in 2019. Out-of-pocket spending on health care constituted nearly 58% of all health expenditures.

Governmental spending on health has been increasing in Nepal, but the health sector still receives only a modest share of general spending (4%). Although budgeting processes have been shifting as a result of the transition from a unitary to a decentralized federal system of governance, governmental health allocations and expenditures continue to be concentrated at the central level, focusing on developing health infrastructure, procuring drugs and vaccines and medical equipment, and recently on the COVID-19 response. In the fiscal year 2021–2022, 74% of the health budget was allocated to the central level, 5% to the provincial level, and 21% to the local level.

2.4. Health Information Technology

All health facilities/programs bear the responsibility of documenting and reporting program/ service statistics through standardized platforms for Management Information Systems (MIS). These platforms include Health Management Information System (HMIS), Logistics Management Information System (LMIS/electronic LMIS (eLMIS), Financial Management Information System (FMIS), Health Infrastructure Information System (HIIS), Planning and Management of Assets in Health Care System (PLAMAHS), Human Resource Information System (HuRIS), Training Information Management System (TIMS), Ayurveda Health Management Information System (AHMIS), Early warning and Reporting System(EWARS), Malaria Disease Information System (MDIS) and the Drug Information Network (DIN). Additionally, these facilities contribute data to various health surveillance systems, such as disease surveillance, vital registration, censuses, sentinel reporting, surveys, rapid assessments, and research initiatives. DoHS takes the lead in managing information systems except for DIN and AHMIS, which are overseen by the DDA and DoAA respectively. (9)

2.5 Health Quality Control

2.5.1. Hospital quality management.

A Policy on Quality Assurance in Health Care Services 2007 was prepared by the MoHP to provide guidelines for the integration of quality-of-care components in health, to ensure that a quality assurance system is in place, and to ensure overall quality improvement activities are well implemented in all health facilities to fulfil consumers' needs. This Quality control of health services in Nepal involves various strategies and mechanisms aimed at ensuring that healthcare provided to the population meets certain standards of safety, effectiveness, and patient satisfaction. Here are some key aspects of quality control in health services in Nepal. (11)

Regulatory Framework: Nepal has regulatory bodies such as the Ministry of Health and Population (MoHP) and the Nepal Health Professional Council (NHPC) responsible for setting and enforcing standards for healthcare providers, facilities, and services.

Accreditation: Accreditation programs evaluate healthcare facilities and providers against established standards to ensure quality of care. In Nepal, the Quality Assurance and Accreditation Section (QAAS) under MoHP oversees accreditation processes.

Training and Education: Continuous training and education programs for healthcare professionals are crucial for maintaining and improving quality standards. This includes ongoing medical education, skills development, and training on patient safety protocols.

Monitoring and Evaluation: Regular monitoring and evaluation of healthcare services help identify areas for improvement and ensure compliance with standards. This can involve routine inspections, audits, and assessments of healthcare facilities and providers.

Patient Feedback Mechanisms: Collecting feedback from patients about their experiences with healthcare services is essential for assessing quality and identifying areas for improvement. Patient satisfaction surveys and complaint mechanisms can help healthcare providers address issues and enhance patient-centred care.

Clinical Guidelines and Protocols: Implementing evidence-based clinical guidelines and protocols helps standardize care delivery and improve clinical outcomes. Health facilities in Nepal often adopt guidelines developed by international organizations like the World Health Organization (WHO) and adapt them to local contexts.

Technology and Information Systems: Utilizing technology and information systems can improve the quality and efficiency of healthcare delivery. Electronic health records (EHRs), telemedicine, and health information systems enable better coordination of care, patient monitoring, and data-driven decision-making.

Community Engagement: Engaging communities in healthcare decision-making and service delivery processes fosters accountability and responsiveness to local needs. Community health programs and participatory approaches can enhance access to quality healthcare in remote areas.

Public Health Initiatives: Addressing broader public health challenges such as infectious disease control, maternal and child health, and non-communicable disease prevention contributes to overall healthcare quality and population health outcomes.

Capacity Building: Strengthening the capacity of healthcare systems, including infrastructure, human resources, and supply chains, is essential for delivering quality health services. This involves investments in training, equipment, facilities, and logistics management.

Table 2: Key roles and responsibilities for quality assurance

Authority	**Key roles and responsibilities for Quality Assurance**	**Monitoring Mechanisms**
a. Federal Level		
MoHP (Quality Assurance and Regulation Division)	Preparing, reviewing, and facilitating the implication of national quality assurance policies and guidelines Establishing service standards and monitoring for all services and types of facilities Guidance and monitoring of the quality of services being delivered by all types of health facilities Review and monitoring of service provision and quality of services delivered Establishing quality standards for drugs, commodities, equipment, and medical supplies	National Quality Assurance Committees Periodic Health Sector Review Meetings

	Ensuring requirements as per the International Health Regulation (IHR) Facilitating registration, renewal, and monitoring of health facilities based on their established criteria and norms	
DoHS	Facilitating implementation, monitoring, and review of the delivery of health services and quality of those services Supporting MoHP in preparation of quality-of-care related policies, protocols, and guidelines of MoHP Ensuring delivery of essential services by all basic health care facilities and other services as per the protocol and health policies	Quality Assurance and Monitoring Committee
Divisions/ Centers	Developing program-specific technical guidance and protocols to ensure preparedness and delivery of health services	Technical Working Groups with the assigned role of quality assurance
b. Province Level		
MoSD/MoHP	Prepare and implement provincial policies, acts, quality standards, and implementation guidelines Ensure delivery of essential services by all facilities and other services as per the policy and protocols Facilitate registration, operation, listing, and regulation of private and cooperative health facilities as per the policy and protocols Facilitate production, and use of health-related commodities, and medicines and ensure the quality of imported medicines and commodities	Provincial Quality Assurance Committees
Directorate/ Centers	Management of logistics and supply chain system of medicines, health commodities, and supplies Facilitate implementation, monitoring, and review of the delivery of health services and the quality of those services by provincial-level health facilities Facilitate dissemination and implementation of program- specific technical guidance and protocols	Technical Working Groups
Health Offices (district level)	Coordinate with the municipal, district, and provincial level authorities to ensure delivery of health services as per the policy and protocol	Technical Committees (if necessary)
c. Local Level		
Municipality	Ensure delivery of basic health and sanitation services as per the federal, provincial, and local health policies, standards, and protocols Facilitate dissemination of information for public awareness and demand creation	Municipal Health Committees

	Coordinate with other sections/sectors to create clean, healthy, and resilient societies	
Hospital/Health Facility	Deliver basic health services as outlined in federal, provincial, and local health policies and by ensuring national standards and protocols	Health Facility Operation and Management Committee with a mandate to review the quality of health services

Minimum Service Standards (MSS) for hospitals are the service readiness and availability of tools for optimal requirements of the hospitals to provide minimum services that are expected from them. This tool entails for preparation of service provision and elements of service utilization that are deterministic towards the functionality of the hospital to enable a working environment for providers and provide resources for quality health service provision. MSS for hospitals reflect the optimally needed minimum criteria for services to be provided but in itself is not an "ideal" list of the maximum standards. This checklist of MSS is different from a program-specific quality improvement tool as it will outline the equipment, supplies, furniture, and human resources required for carrying out service but not detail the standards and operating procedures of any service. The results of the Nepal Health Facility Survey 2015 showed that among the health facilities that were assessed only 13 % of them had all seven basic equipment items- adult weighing scale, child weighing scale, infant weighing scale, thermometer, stethoscope, blood pressure apparatus and a light source for service provision. The availability of all supplies and equipment defined for standard precaution control was as low as 0.2%, all basic Laboratory services in 12% and only 3% of facilities had client feedback mechanisms in place. This was an alarming situation. During that period, minimum service standards were rolled out in 83 district-level hospitals and were evident to contribute to the quality of services provided by hospitals with instances of improved governance, management, clinical and support services. This encouraged MoHP to put its efforts into setting the minimum service standards for hospitals at secondary and tertiary levels and at the same time contextual revision of MSS for district hospitals to set MSS for primary level hospitals. The revision and development of the tool took into series of steps beginning with the formulation of a Technical Working Group and selection of subject experts and technical coordinators and consultative workshops and meetings. The key guiding documents are the Constitution of Nepal 2015, National Health Policy 2014, Policy on Quality Assurance in Health Care Services, 2007, Public Health Service Act 2015, Nepal Integrated Health Infrastructure Development Standards 2016, Nepal Health Sector Strategy 2015- 2020 and Guideline on Health Institution Establishment, Operation and Upgrading Standards, 2070 but not limited to them. (12)

2.6 Certification of Health Practitioner

Nepal Health Professional Council (NHPC) is an autonomous body established under the Nepal Health Professional Council Act 1996. This council aims to register all the "Health professionals" other than medical doctors, Nurses, Pharmacists, and Ayurveda according to their qualifications; and bring them into a legal system to make their services effective with quality and timely in a scientific manner.

The Nepal Medical Council (NMC) is the government authority established as per the NMC Act to conduct various activities, including the registration of medical doctors in Nepal. The primary role of the council is to assure and promote quality in the medical profession to protect the health care seekers, foster ethical conduct and develop and maintain high academic and professional standards.

Nepal Nursing Council (NNC) was established under the Nepal Nursing Council Act 1996 and came into force on 16 June 1996. The first amendment of the act was done on 17th January 2002 A.D.

The power, function and duties of these councils shall be as follows: -

- To formulate the policy required to operate the profession smoothly
- To provide recognition to a teaching institution,
- To evaluate and review the curriculum, terms and conditions of admission, examination system and other necessary terms and conditions and infrastructure of a teaching institution